

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov

Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 1, 2019

Ms. Catherine Rooney, Manager Harvey House Ltd 1860 Main Street Castleton, VT 05735-7709

Dear Ms. Rooney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 22, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

imlaMCdaDN

Division of Licensing and	1 Protection	•		FORM APPROVED
STATEMENT OF DEFICIENCIES	Contract to the second	(X2) MULTH	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	J	COMPLETED
				С
	0380	B. WING	· · · · · · · · · · · · · · · · · · ·	04/22/2019
NAME OF PROVIDER OR SUPPL	IFR STREETA	DODOSS CITY	STATE, ZIP CODE	The state of the s
	, , , , , , , , , , , , , , , , , , ,	UN STREET	OTATE, ZII COBE	
HARVEY HOUSE LTD		TON, VT 05	735	
(X4) 10 SUMMAR	Y STATEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF CORRECTI	ON
PŘÉFIX (BACH DEFICI	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	ON (X5) .D.BF COMPLETE
TAC REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE
	7	·		
R100 Initial Commen	ts:	R100		
% <b>∧</b>	alla territoria de de la constanta		44	
Anjunannounce	ed on-site investigation of two (2) conducted by the Division of			
Licensing and F	Protection on 4/22/19. There were			
	ngs identified as a result of these			
	indings Include:		·	}
		:		
R134 V. RESIDENT (	CARE AND HOME SERVICES	R134		ļ
SS=D		•	027	·
5.7. Annonne	•		K 12 -1	
5.7 Assessmer		•	Assosment de medication no	<del>\</del>
5.7.a An asses	sment shall be completed for	: i	La Secotion was	tremposon
	ithin 14 days of admission,	1 .	, n	A 1
	the physician's diagnosis and		completed o	154/14
orders, using ar	assessment instrument provided	İ	Co pool	a sun o
by the licensing	agency. The resident's abilitles cation management shall be		Lasil cheer	rex pho
assessed within	24 hours and nursing detegation		is done within	The .
implemented, if	necessary.	!	SHLOUTS OF	Jan Selver
			GC ( V(C C,	
	MENT is not met as evidenced	1	·	
: by: Resed on reside	ent and staff Interview and record	 	·	
	ty failed to ensure that the		·	į
	se (RN) completed an admission		. ,	· •
assessment for	one (1) of three (3) residents in			
the sample, (Re	sident # 1). Findings include:	:	•	z.
Per record revie	w, Resident #1 was admitted on			
3/5/19 and disch	arged to the hospital on 3/25/19,			
20 days later. S/	he was readmitted to the facility			
on 4/9/19. The ri	esident assessment instrument in			
	ord was incomplete and was not			
signed or dated	by the RN. There is no evidence t Resident #1 was assessed by	•		
	g medication management.			
ार र र र र र र <b>्रा</b> स्त्र	2 I meane it management.			
	h the facility-Manager on 4/22/19			
	e confirmed that the assessment			
ivision of Licensing and Protection	THE REPRESENTATIVE'S SIG			1300 CO-ON
COLOLO	WAS CONTROL REPRESENTATIVES SIG		TITLE YEN	2/10/19 2/10/19
	m hosk	W.C	enouser i	2110112

R134-R266 POC'S accepted 6/28/19 SFREMENRA/PM

Attn. Sissen Froomon.

Division	of Licensing and Pro	otection	<u> </u>		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1 1	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
W-277		0380	8. WING		C 04/22/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE; ZIP CODE	
HARVEY	HOUSE LTD	CASTLET	N STREET ON, VT 05	735	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY:FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
R134	Continued From pa	age 1	R134	t	
	evidence that the p were completed ha S/he also confirme been assessed by medication manage Per interview with F PM, s/he confirmed his/her ability regar	complete, and that there was no carts of the assessment that ad been completed by the RN. It is a that Resident #1 had not the RN regarding the ability of ement per the regulation.  Resident #1 on 4/22/19 at 2:15 is that the RN did not assess riding medication management.			
R135 SS=D	V. RESIDENT CAR	RE AND HOME SERVICES	R135	R138	
	5.5 Assessment			resident oese	25 mont
	nursing care, the re licensed nurse with to the home or the	requires nursing overview or esident shall be assessed by a nin fourteen days of admission commencement of nursing assessment instrument ensing agency.		strok Justice that the before of new many	espected espech 14 days 1321012
	by: Based on staff interfacility failed to ens- completed within 14 of three (3) resident	NT is not met as evidenced rylew and record review, the ure that an assessment was 4 days of admission for one (1) ts who require nursing nple, (Resident # 1). Findings			
	3/5/19 and discharg 20 days later. S/he Resident # 1 receiv medication manage	Resident #1 was admitted on ged to the hospital on 3/25/19, was readmitted on 4/9/19. Wes nursing overview through ament. The resident ment in the medical record was			

Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING 0380 04/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1860 MAIN STREET HARVEY HOUSE LTD CASTLETON, VT 05735 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) 1D 10 (XS) (EACH OFFICIENCY MUST BE PRECEDED BY FULL) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAĞ DEFICIENCY) R135 Continued From page 2 R135 incomplete and was not signed or dated by the RM. There is no evidence in the record that Resident #1 was assessed by a licensed nurse within 14 days of admission. Per interview with the facility Manager on 4/22/19 at 12:15 PM, s/he confirmed that the resident did require nursing overview and that the assessment instrument was incomplete. The manager also confirmed that there was no evidence that the completed parts of the assessment had been completed by the licensed nurse. R163 V. RESIDENT CARE AND HOME SERVICES R163 . SS≃D 5.5 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a registered nurse (RN) conducted an assessment consistent with the physician's diagnosis and orders of the resident's care needs for one (1) of three (3) residents in the sample, (Resident # 1). Findings include: Per record review, Resident #1's medications are administered by unlicensed staff. The resident

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Division	of Licensing and Pro	tection				<u> </u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTERI A. BUILDING	,£ CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		0380	ß. WING		04/2	: 2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
t t a ma chi's	MANAGATA	1860 MAI	STREET			
HARVEY	HOUSE LTD	CASTLET	ON, VT 057	35		
(X4) IÓ PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETE DATE
R163	Continued From pa	ge 3	R163			
	incomplete and was RN. There is no evi RN conducted an a	nent in the medical record was not signed or dated by the dence in the record that the ssessment consistent with the is and orders of the resident's				
	at 12:15 PM, s/he of medications are ad The Manager also devidence that the R consistent with the orders of the reside		D165			
SS±D	5.10 Medication Ma	E AND HOME SERVICES anagement requires medication	R165	Rolls mende medication of delegation of	<b>,</b> ⊖	
		censed staff may administer the following conditions:	,	completed o	y vy	
	medications, and is i. Teaching desig for medication adm appropriate inf condition, relevant is side effects; ii. Establishing a communication with resident's condition as well as changes iii. Assessing the need for any chang	e proper administration of responsible for: nated staff proper techniques inistration and providing ormation about the resident's medications, and potential process for routine designated staff about the and the effect of medications,				

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Division	n of Licensing and Pro	otection				
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION .		E SURVEY IPLF1FD
		0380	B. WING			C 22/2019
	PROVIDER OR SUPPLIER	/ / / / / / / / / / / / / / / / / / /	DDRESS, CITY, ST	TATE, ZIP CODE	· ·	<del>-</del>
HARVE	Y HOUSE LTD		TON, VT 0573	35		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL: LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
R165	Continued From pa	age 4	R165			
	performance in care instructions.	rrying out the nurse's				
	This REQUIREMEN	NT is not met as evidenced				
	Based on staff inter facility failed to ense (RN) provided appro- staff who administe	erview and record review, the cure that the Registered Nurse, ropriate oversite of unlicensed er medications to one (1) of				
	three (3) residents i Findings include:	in the sample, (Resident # 1).				
	managed by the factories and unlicensed state record that an RN homedication delegate #1's condition, medical	Resident #1 is medication cility and receives medications aff. There is no evidence in the has provided teaching to the led staff regarding Resident dications, and potential side so no evidence in the record				
	that the RN assessereviewed the medic assessment instrumincomplete and was RN. There is no evicent	sed Resident #1's condition or cation regime. The resident ment in the medical record was a not signed or dated by the idence in the record that assessed by the RN regarding				!
	at 12:15 PM, s/he.c. administer Resident manager also confir medication orders h	he facility Manager on 4/22/19 confirmed that unlicensed staff at #1's medications. The firmed that Resident #1's had not been reviewed by the N had not provided oversite of ications.			·	
R189 SS=D		REAND HOME SERVICES	R189			
	5.12.b. (3)	•				

	Division of Licensing and F	Protection			, 0
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
	<u> </u>	0380	B. WING		C 04/22/2019
•••	NAME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CITY.	STATE, ZIP CODE	
	HARVEY HOUSE LTD		IN STREET TON, VT 05	735	
	PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RUSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
	R189 Continued From p	page 5	R1 <b>8</b> 9		
	nuising overview record shall also of annual reassessment; physicand current orders changes in the restaken; and reports telephone orders and resident plan.  This REQUIREMED by: Based on staff interfacility failed to en was completed for in the sample, (Resident plan of care was experienced by the plan of care had not care had n	erview and record review, the sure that a resident plan of care rone (1) of three (3) residents esident #1). Findings include:  Resident #1 was admitted on rged to the hospital on 3/25/19, a was readmitted on 4/9/19, noe in the record that a resident ever developed for Resident #1. the facility Manager on 4/22/19 confirmed that the resident ot been developed and that ence of a resident plan of care		PIBO Correptent STITIO I Just to be seeked when road Fract new Leeked	ated 1 class that ent leaves well as
	R213 VI. RESIDENTS' F SS=F	RIGHTS	R213		
	consideration, resp resident's dignity, i	t shall be treated with pect and full recognition of the individuality, and privacy. A ca resident to waive the			

Division	of Licensing and Pro	otection	•		FORM APPROVE
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		0380	B. WING		04/22/2019
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY	, STATE, ZIP CODE	191
HARVEY	HOUSE LTD		IN STREET		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX YAĞ	(EACH CORRECTIVE ACTION SMOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILO BE COMPLETE
R213	Continued From pa	ige 6	R213		
	N				
	<u> </u>	•			
	This REQUIREMENT by!	NT is not met as evidenced			
		ons and resident and staff	1		:
		failed to ensure that			i
	resident's rights we and individuality.	re honored regarding dignity	: '	10013	
	and individuality.			RZI	
	Per interview with R	Resident #1 at on 4/22/19 at		3 Detrachers	5 harre
		d that residents cannot even		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	h
:	have water in their i	rooms. The Manager does not		10,000s to	-4-1W.X-
:		t can stain the carpet. Staff	:	CT = 8 m	2=18=
		en to go to bed and that		other obmo	
,	residents must go to	bed even if they don't want	:	Kitchen cour	Tondeown.
	to.				
1	Phononical Control		į	take todani	ver vacon
į	Mer interview with the	ne Medication Delegate, on	:		en West
	recidente arà not all	s/he confirmed that the owed to have food or drink	i		<u> </u>
		their rooms. S/he stated that		Posidents de	reliro
		strict about what residents		The second secon	ì
	can and can't do. Th	ne resident's are not allowed			ewo.
	to have food or drint	ks past 8:00 PM in common		around 8pm	pr-t-frest
•	areas. S/he stated ti	hat smoking times end at 7:00		To some spirit	
	PM although the add	mission agreement states that	•	Choice to lisi	UN TO
	there is no smoking	allowed between 8:30 AM -		choice to list radio-read till they fall	COCOLCY!
	8:00 PM.			1112 ac 50 18	200/200
	Per intendew with th	e Manager on 4/22/19 at		Att I was too	, we except
	12:00 PM s/he state	ed that "a lot of referrals come			•
	from the crisis stend	lown, where they can do what	-		
	they want. When the	ey come here and are told, no			
	you can't eat whene	ver you want to, or no, you			
	can't stay up until mi	idnight drinking coffee, they			
	don't like it". S/he als	so stated, "you have to kind of			
	treat them like kids".	During a second interview			
		4/22/19 at 4:30 PM, she			
		ents cannot have food or			
	urinks in their rooms ensing and Protection	, and that they are expected			

Division of Licensing and Pr	otection			PRINTED: 05/09/201 FORM APPRÓVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDÉR SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0380	B. WING		C 04/22/2019
NAME OF PROVIDER OR SUPPLIER	STREETA	ODRESS, CITY, S	TATE, ZIP CODE	1 04/22/2013
HARVEY HOUSE LTD	1860 MA	IN STREET TON, VT 0573		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE COMPLETE
R213 Continued From pa	age 7	R213		. ,
to be in their rooms tight the residents a admission.	after 8:00 PM. S/he stated are aware of the rules prior to			:
R260 IX. PHYSICAL PLA SS=F	NT	R266		i. :
9.1 Environment				;
9.1.a The home ma safe, functional, sar comfortable environ	ust provide and maintain a nitary, homelike and iment		2000 On April 2	26 2019
by: Based on observation	IT is not met as evidenced ons and staff interviews, the stain a sanitary, homelike	<u> </u>	Endport 2 Answ medr scholable he scholable he	fredclawie as been a worth
4/22/19 between 11: bedrooms observed on dressers and nigh	of resident bedrooms on 30 AM and 4:50 PM, all to have a thick layer of dust ht stands. The window I with dust. The ceiling fans in thick dust.	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	wate ser	2 all been
4/22/19 at approximate walkthrough of the factorial above issues. The Markthat there is a cleaning that the cleanin	Medication Delegate on ately 3:15 PM during a acility, s/he confirmed the ledication Delegate stateding schedule, but when things and they can't get to it.	<b>\</b>	10022 Keep 11	ig in order
Delegate, it was note the doorways of the l	ough with the Medication of that there were cobwebs in citchen and television room. kitchen had a thick greasy		·	

Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING 0380 04/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 1860 MAIN STREET HARVEY HOUSE LTD CASTLETON, VT 05736 SUMMARY STATEMENT OF DEFICIENCIES (X4) RD PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) R266 Continued From page 8 R266 layer of dust on the fins. Thick heavy smoke began to come from the oven, the Medication Diffegate turned on the ceiling fan, removed the chicken from the oven, and placed it on top of the oven under the fan, and opened the windows in the kitchen. S/he then placed the chicken back in the oven. Per interview with the Medication Delegate at that time, s/he confirmed that having food out under a dirty running fan was a food contamination issue.